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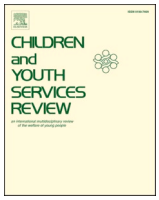

The wellbeing and support experiences of parents and caregivers from South and Southeast Asian refugee backgrounds during the First 2000 Days: A systematic review

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ABSTRACT

There is growing scholarly attention concerning the wellbeing experiences of people from refugee and asylum-seeking backgrounds, particularly in relation to antenatal and postnatal care in countries of resettlement. However, less is known about early childhood support for refugee and asylum-seeking parents during the First 2000 Days of a child's life (conception to age five). There is also little understanding of the needs of refugees and asylum-seekers from South and Southeast (S/SE) Asia for whom there may be unique cultural considerations regarding parenting and support. This systematic review therefore aimed to explore the emotional and physical wellbeing and support experiences of refugee and asylum-seeking families (mothers, fathers, and other family members with caregiving roles) from S/SE Asia during the First 2000 Days. This review was guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA). We identified publications through a systematic search of six databases. Eligible papers were peer-reviewed, primary data studies published in English, conducted in middle- to high-income countries of resettlement, and included data that could be disaggregated for S/SE Asian families. Of 5,770 publications, 13 articles met inclusion criteria. While our review aimed to explore the experiences of various family members, included papers focused primarily on the experiences of refugee women. Our review found that S/SE Asian refugee parents reported various challenges to physical and emotional wellbeing during the First 2000 Days ranging from nutrition and diet concerns to feelings of anxiousness, grief, isolation, and feelings of distress in healthcare settings. Parents also expressed a level of trust and satisfaction with maternity care during resettlement, however, these experiences were challenged by a lack of culturally responsive care. Findings speak to the importance of informal social supports for S/SE Asian refugee parents, and culturally safe, formal supports where parents feel comfortable to voice their concerns.

1. Introduction

Many women from refugee or asylum-seeking backgrounds will require maternity and early childhood care in countries of resettlement (Pangas et al., 2019). However, there are maternal and broader antenatal and postnatal health disparities when compared to migrant or native-born groups in high-income resettlement countries (Gibson-Helm et al., 2015; Kandasamy et al., 2014; Liu et al., 2020). Similarly, there is evidence of lower uptake and availability of support during the early childhood period for children and families from refugee backgrounds (Baker et al., 2019; Poureslami et al., 2013). This is of concern as the First 2000 Days (conception to age 5) are considered a critical period for children's cognitive, social, emotional, and physical health and development, highlighting the importance of early-life supports in promoting positive outcomes for parent–child wellbeing (NSW Health, 2019).

Among the largest sources of refugees to high-income resettlement countries are people from S Asian countries (e.g., Afghanistan) and SE Asian countries (e.g., Myanmar) (UNHCR, 2022a). Compared to other migrant and non-migrant groups, women from these countries experience specific adverse obstetric outcomes at higher rates, such as stillbirth in S Asian women (Berman et al., 2020; Davies-Tuck et al., 2017), perineal trauma in S/SE Asian women (Brown et al., 2018; Sørbye et al., 2022) and gestational diabetes mellitus (GDM) in S/SE Asian women (Teede et al., 2011). There is also a shortage of research on the physical and emotional wellbeing and support experiences of families from

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refugee backgrounds in general. However, within this overall shortage, women from S/SE Asia including those from emerging refugee communities (e.g., Myanmar) are often missed in refugee and asylum-seeker population studies (e.g., Behboudi-Gandevani et al., 2022; Dennis et al., 2016; Verschuuren et al., 2020). There is also scant literature for fathers from refugee backgrounds generally, and little understanding of the needs of refugees and asylum seekers from S/SE Asia, for whom there may be unique cultural considerations regarding parenting and support. As such, this review aimed to understand the emotional and physical wellbeing and support needs and experiences for S/SE Asian refugee and asylum-seeking women, men, and broader family members during the First 2000 Days in resettlement countries.

1.1. Terminology

It is important to recognise the diverse experiences of refugees, asylum seekers, and migrants; terms which are often used inconsistently within the literature. Migrants – unlike refugees and asylum seekers – may voluntarily leave their country and return at any time (Amnesty International, 2019; UNHCR, 2020). As defined by the United Nations High Commissioner for Refugees (UNHCR), refugees are people who have fled their country due to "persecution, war or violence" for reasons of "race, religion, nationality, political opinion or membership in a particular social group" (UNHCR, 2020).

Like refugees, asylum seekers leave their country of origin given situations of persecution or human rights violations. However, refugees have had their claim for refugee status recognised and are formally resettled, while asylum seekers are awaiting a decision for recognition and formal protection (UNHCR, 2020). As such, research is needed that identifies the unique wellbeing and pregnancy experiences of refugee and asylum-seeking families who may be at-risk in comparison to migrant families (Pangas et al., 2019; Rogers et al., 2021). The current review aims to address this gap by focusing on refugee or asylum-seeking families during resettlement.

The 'First 2000 Days' is a common term in early childhood studies used to describe the period from conception to age 5. The First 2000 Days are a key developmental period for children's cognitive, social, emotional, and physical wellbeing. Early-life experiences during this time are often predictive of a person's future health and wellbeing, indicating the importance of exploring early-life supports to ensure positive parent–child outcomes (NSW Health, 2019). This term is increasingly being used in both the academic literature, as well as policy and practice and mainstream documentation (Mendoza Diaz et al., 2023; Nelson et al., 2022; NSW Health, 2019).

We define wellbeing in accordance with the World Health Organization's multidimensional definition, where wellbeing,"…enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community" (WHO, 2022). Wellbeing is also "…a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, n.d.).

1.2. Background

Increasing numbers of families are fleeing countries in the S/SE Asian subregion due to ongoing humanitarian issues and climate concerns, with approximately 80 % of the world's climate-related displacement in the Asia-Pacific region (Internal Displacement Monitoring Centre, 2022; UNHCR, 2023). Two crises in particular – occurring in Afghanistan and Myanmar – have seen millions displaced internally and thousands fleeing their countries, with these numbers expected to significantly increase (UNHCR 2022b; 2023).

Refugees and asylum seekers face various challenges to wellbeing including poorer mental health than native-born populations upon arrival in resettlement countries (Chen et al., 2017; Steel et al., 2009). Poorer wellbeing outcomes may be pronounced for asylum seekers due to uncertain visa status, asylum claim rejections, immigration detention or prolonged processing times (Li et al., 2016). In regard to the First 2000 Days specifically, an established body of literature highlights that refugee women from various backgrounds in resettlement countries face poorer wellbeing when compared to native-born (Harakow et al., 2021; Rees et al., 2019) or migrant women (Gibson-Helm et al., 2015). Poorer antenatal and postnatal health outcomes for S/SE, and West Asian refugee women generally include GDM, pre-eclampsia, pre-term birth, stillbirth, low birth weight, infant admission to neonatal intensive care units, or women's admission to high-dependency units (Gibson-Helm et al., 2015). Refugee women from diverse ethnocultural backgrounds also experience a greater burden of peri- and post- natal mental health challenges such as anxiety, depression, and posttraumatic stress disorder (Heslehurst et al., 2018; Navodani et al., 2019). Compared to refugee and migrant women, asylum-seeking women may experience greater health and psychosocial difficulties including greater postnatal depressive symptoms (Dennis et al., 2017) and poorer obstetric outcomes compared to the broader population (Hadgkiss & Renzaho, 2013; Verschuuren et al., 2020).

Research with the general population indicates that fathers may also experience impacts to wellbeing such as anxiety (Lever Taylor et al., 2019) or depression during the First 2000 Days (Garfield et al., 2014; Kothari et al., 2019). However, there is scant research to understand the experiences and needs of fathers, as well as other family members who may have important roles for the care of children in particular social or cultural contexts (Kim et al., 2017; Lee et al., 2016).

While research suggests that refugee women – and potentially men and other family members – face issues with health and wellbeing in the First 2000 Days, there is little understanding of the specific support needs they may have. Limited interpreting support, treatments performed without the women's consent, concerns around confidentiality, cultural stigma, and financial and transport concerns, are cited by refugee women and their families as barriers to accessing culturally responsive and safe healthcare during pregnancy (Henry et al., 2019; Willey et al., 2020). As such, there is a need for organisations and services to provide culturally responsive care – care that considers the cultural identity, values, and practices of the patient, respecting their support needs and preferences, and understanding how culture informs a patient's views of health and help-seeking (Markey & Ibeajaero, 2022). Providing accessible and affordable services, support to navigate systems, and access to interpreters are also part of culturally responsive care (Rogers et al., 2020).

Support during early childhood may also be limited – formal supports for refugee parents' physical and mental health often end soon after babies are born, despite potentially long-lasting levels of need beyond the first-year post-birth (Ahmed et al., 2008; O'Mahony et al., 2012; Schmied et al., 2017). This is of concern, as caregivers are faced with continued challenges to wellbeing including processing experiences of trauma and loss while simultaneously undertaking parenting responsibilities and navigating changing family dynamics and identities (Fazel & Betancourt, 2018). Of the limited studies that focus on refugee caregiver wellbeing in early childhood, parental psychopathology has been shown to predict children's wellbeing outcomes including emotional and conduct problems (Eruyar et al., 2018) and contact with psychiatric services (Back Nielsen et al., 2019). Identifying ways to appropriately support caregivers during the First 2000 Days may therefore help to promote the health and wellbeing of refugee children in the short and longer term.

As seen in the above overview of existing literature, little is known about the wellbeing and support experiences of this specific group of refugees, particularly for those from S/SE Asia, for additional members of the family unit, and for families through to the First 2000 Days. This study therefore aimed to provide a systematic review of the literature concerning the wellbeing experiences and support needs of refugee and asylum-seeking families from S/SE Asia in middle- to high-income resettlement countries. This review addresses two research questions: (1) What are the emotional and physical wellbeing experiences of S/SE

Asian refugee and asylum-seeking women, men, and their broader family members (who may act as carers) during the First 2000 Days? (2) What supports do S/SE Asian refugee and asylum-seeking women, men, and their broader family members (who may act as carers) have and need during the First 2000 Days?

2. Methods

This systematic review was guided by PRISMA guidelines (Page et al., 2021), and the review protocol was prospectively registered with PROSPERO (reference ID: CRD42021259542).

2.1. Inclusion and exclusion criteria

We adopted the PICo framework (Population, phenomenon of Interest, Context) (Stern et al., 2014) to guide our review questions, aims and inclusion criteria. Studies were eligible for inclusion if they were peer-reviewed, primary data studies published in English. No restrictions were placed on publication date, with qualitative, quantitative, and mixed methods studies all eligible for inclusion. Studies that reported findings relevant to the wellbeing experiences or support needs for S/SE Asian refugee or asylum-seeking women or family members (e.g., grandparents involved in childcare) during the First 2000 Days (conception to age 5) were included. Inclusion criteria surrounding family members' level of involvement in childcare remained broad, with no specific criteria applied regarding number of hours or days that these members were involved in childcare.

For the purpose of this review, we were inclusive in our criteria regarding the definition of 'wellbeing' given the relative dearth of literature in this area. As such, wellbeing was considered a holistic category, considered broadly in line with the World Health Organization's multidimensional definition (WHO, 2022).

In the current review, when referring to support for wellbeing during the First 2000 Days we refer to emotional (affection or empathy), instrumental (physical assistance), and informational (knowledge or advice) support (Bedaso et al., 2021; Fahey & Shenassa, 2013; Fakhraei & Terrion, 2017).

The context in which participants in included studies reported their wellbeing or support needs or experiences was kept broad and included formal health services (e.g., government, non-government, private, community-based) and informal care (e.g., family) in middle- to high-income resettlement countries. Inclusion criteria for dimensions of support were also kept broad to include facets such as parenting, housing, education and other social and health supports for caregivers. Studies which explored supports for infants and children such as playgroups were included – though only if these studies included adult participants and reported the experiences of parents and caregivers in these settings.

Middle- to high-income countries were defined according to categorisations provided by the World Bank, based on gross national income per capita data. South Asian countries were also classified according to the World Bank and include Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, and Sri Lanka (World Bank, 2023). Southeast Asian countries were defined according to peak body organisation, the Association of Southeast Asian Nations and include Brunei, Cambodia, East Timor, Indonesia, Myanmar, Laos, Malaysia, Philippines, Singapore, Thailand, and Vietnam (ASEAN, 2020).

Studies which used the terms 'migrants' or 'immigrants' but did not provide information to determine whether participants were refugees or asylum seekers were excluded (e.g., Shafiei et al., 2015). Studies which included refugees, asylum seekers and other participant groups (e.g., migrants, non-migrant groups) but did not disaggregate data or separate findings for S/SE Asian refugee or asylum seeker participants were excluded (e.g., Hennegan et al., 2015). The experiences of internally displaced groups and people in refugee camps or transit countries were excluded, as the focus of this review was to synthesise findings relevant to health systems and wellbeing outcomes in middle- to high-income countries of resettlement.

2.2. Search strategy and data collection

Eligible records from inception to 7 January 2022 were identified using the following databases: Cumulative Index to Nursing and Allied Health Literature (CINAHL), Embase, Emcare, PsycINFO, PubMed, and Scopus. The search strategy was developed in collaboration with an expert research librarian. Keywords included 'refugees', 'asylum seekers', 'pregnancy', 'early childhood', 'wellbeing', and 'family' (see Appendix A for full database search strategies). Additionally, reference lists of previous relevant review papers and reference lists of included studies were manually searched. All titles and abstracts were screened by the first author with a random subset of 10 % screened by an independent reviewer. Inter-rater reliability was high (Viera & Garrett, 2005) with full agreement between reviewers ($k = 1.0$).

2.3. Quality appraisal

The first author conducted quality assessments of the final set of included papers using the Mixed Methods Appraisal Tool (MMAT) – a tool used to assess the quality of quantitative, qualitative, and mixed-methods empirical research studies (Hong et al., 2018). A random subset of 30 % of included full texts were assessed for quality by other authors, with no discrepancies between reviewers. Due to the small number of studies, no exclusions were made on the basis of quality.

2.4. Data extraction

All papers which met inclusion criteria for the first stage of screening (title and abstract phase) then underwent full-text review by the first author to examine whether these studies explored the wellbeing or support needs and experiences for S/SE Asian families during the First 2000 Days. Published studies which met eligibility criteria in this second full-text review phase subsequently underwent thorough review for the data extraction stage. The first author used a pre-designed table to extract relevant information from each study. This information was then cross-checked by all authors. Data extracted included: resettlement country of study, study aims, study design and methodology, sample size and sample characteristics, measures or experiences of wellbeing or support, and findings relevant to the research questions such as the reported physical or emotional wellbeing experiences of caregivers, their support experiences or their support needs in various service settings, as well as service provider experiences in supporting S/SE Asian refugee and asylum seeker caregivers in the First 2000 Days.

3. Results

The initial database search resulted in 5,762 articles for consideration. A further 8 articles (7 from the reference lists of previous review papers, and 1 from a reference list of an included study) were also included for review, resulting in a total of 5,770 articles. Of the 5,770 papers identified, 13 peer-reviewed papers were determined eligible for inclusion in this study (see Fig. 1 for PRISMA selection process).

3.1. Description of studies

Twelve publications were qualitative, and one quantitative. The thirteen publications reported on a total of nine studies. Four qualitative papers (Riggs et al., 2016; Riggs et al., 2020; Yelland et al., 2014, 2016) used the same sample. A second, mixed-methods study by Kingsbury and colleagues (2018, 2019) resulted in one qualitative paper (Kingsbury et al., 2018) and one survey-based quantitative descriptive paper (Kingsbury et al., 2019). For further detail of included studies including study aims, sample, methods, and relevant findings, see Table 1. For an

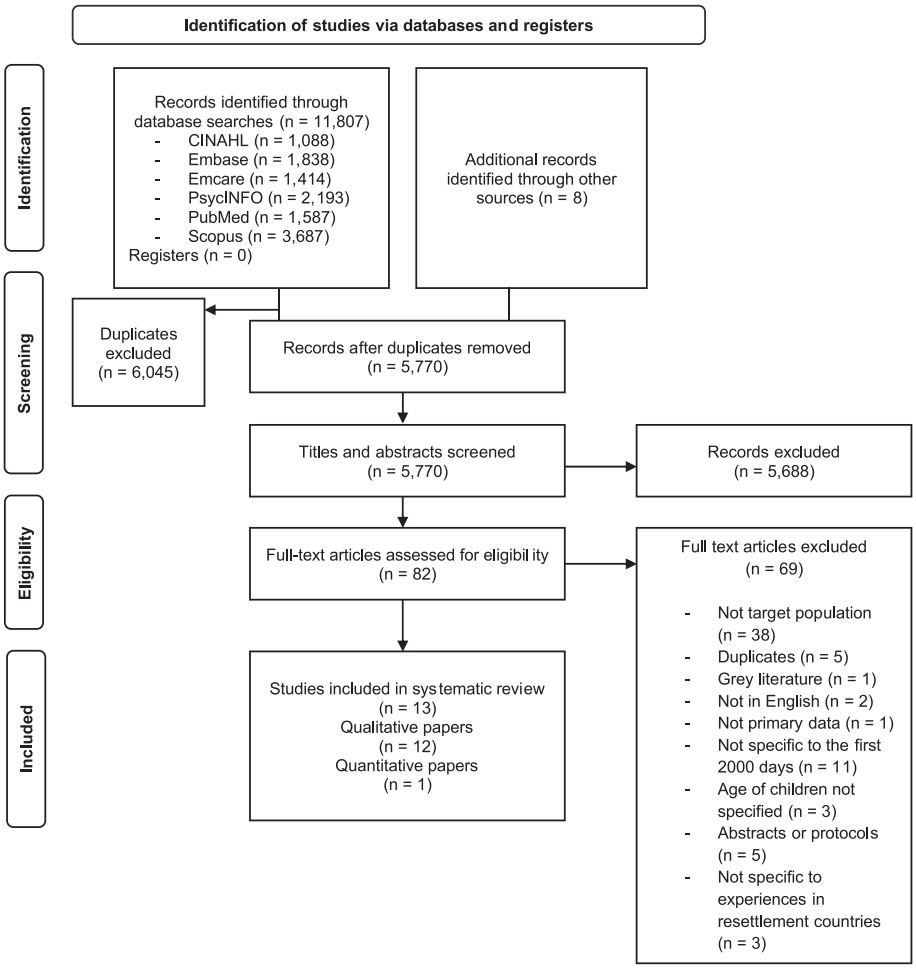

Fig. 1. PRISMA flow diagram.

overall summary of the characteristics of included studies, see Table 2.

The thirteen included articles were published between 2000 and 2021, and predominantly within the last 10 years. The source refugee countries in the included studies were Afghanistan (Riggs et al., 2016; Riggs et al., 2020; Yelland et al., 2014, 2016; Russo et al., 2015), Myanmar (Joseph et al., 2019a; LaMancuso et al., 2016; McLaughlin & Guilfoyle, 2013; Niner et al., 2013; Riggs et al., 2017), Bhutan or Nepal (Kingsbury et al., 2018, 2019), Vietnam (Hyman & Dussault, 2000; Joseph et al., 2019a), and Cambodia and Laos (Hyman & Dussault, 2000). The main resettlement countries were Australia (Joseph et al., 2019a; McLaughlin & Guilfoyle, 2013; Niner et al., 2013; Riggs et al., 2016; Riggs et al., 2017; Riggs et al., 2020; Yelland et al., 2014, 2016; Russo et al., 2015), the US (Kingsbury et al., 2018, 2019; LaMancuso et al., 2016) and Canada (Hyman & Dussault, 2000).

Eight articles included refugee participants (Hyman & Dussault, 2000; Joseph et al., 2019a; Kingsbury et al., 2018, 2019; McLaughlin & Guilfoyle, 2013; Niner et al., 2013; Riggs et al., 2017; Russo et al., 2015). Five articles included participation from refugees and service providers (LaMancuso et al., 2016; Riggs et al., 2016; Riggs et al., 2020; Yelland et al., 2014, 2016). Most studies explored the experiences of S/SE Asian refugee women, with four papers from the same overarching study including the wellbeing and support experiences of Afghan refugee men during the antenatal period and up to 12 months post-birth (Riggs et al., 2016; Riggs et al., 2020; Yelland et al., 2014, 2016). In these papers, findings regarding men were primarily related to men's experiences supporting their wives during the antenatal and postnatal periods, with less focus regarding men's wellbeing specifically.

Only one study (McLaughlin & Guilfoyle, 2013) explored caregiver experiences beyond the postnatal period, into early childhood. No studies included asylum seeker participants or the experiences of other caregivers.

3.2. *Quality of included papers*

The MMAT includes two initial screening questions for all study designs: (1) are there clear research questions, (2) do the collected data adequately address the research questions? (Hong et al., 2018). All 13 included studies met these minimum screening requirements.

Most qualitative studies were found to be of good quality in terms of MMAT criteria for appropriateness of the qualitative approach to address research questions and adequacy of sampling and data collection measures. Study findings and interpretation of findings were substantiated by the data collected. Coherence was shown between data sources, collection, analysis, and interpretation with relevant methodologies appropriately described in these included studies (Hong et al., 2018).

There were some concerns around methodological quality in the quantitative descriptive study (Kingsbury et al., 2019) and one qualitative study (Niner et al., 2013). In relation to the quality of the quantitative descriptive study by Kingsbury et al. (2019), two of the five MMAT criteria were met: low non-response bias with minimal missing data (6.7 %), and appropriate statistical analysis using regression techniques for the collected data (Kingsbury et al., 2019). A validated social support measure was used though how the measure was modified was not clearly explained. Further, no sampling frame nor approach to obtain a representative sample of Bhutanese refugee women were

Table 1
Summary of included articles.

Author, publication year	Country of study	Study aims	Study design and methodology	Sample/sampling	Measures	Findings relevant to review
Hyman & Dussault (2000)	Canada	Examine health behaviours, social support and stress among pregnant Vietnamese, Cambodian and Laotian women with varying levels of acculturation, to understand the relationship between migration and low birth weight.	Qualitative: semi-structured interviews.	$n = 17$ Vietnamese, Cambodian and Laotian refugee women were identified through: an interpretationand orientation agency for SE Asians in Montreal; community health departments; health professionals; cultural and religious organisations; word of mouth.	Measure/s not stated.	Increased levels of acculturation among participants were linked to dieting during pregnancy, lack of social support, and higher stress, having implications for low birth weight in SE Asian women. Some women noted financial pressures which impacted wellbeing during pregnancy.
Joseph et al. (2019a)	Australia	To gain insight into how refugee women from Vietnam and Myanmar experience breastfeeding, and how this is impacted by social supports and western biomedical services.	Qualitative: interviews. Analysed thematically and guided by feminist methodological inquiry. Drawings were analysed using the critical visual analytical framework.	$n = 38$ refugee women: Karen (12), Karenni (3), Chin (4), Kachin (3), Vietnamese (22). Using a theoretical sampling method, Vietnamese women were recruited from a Catholic community by a Vietnamese pastoral worker. Women from Myanmar were recruited by a Burmese bicultural worker.	Semi-structured interview guide.	Reduced breastfeeding length in Vietnamese women and women from Myanmar may be influenced by uncertainties and conflicting understandings around culture and health in the "western" context, compared to their transgenerational and traditional beliefs.
Kingsbury et al. (2018)	United States	Explore the pregnancy experiences of refugee women from Bhutan (Nepali descent) in Northeast Ohio, with a focus on their social network structure and perceptions of social support.	This is a mixed methods study. This paper reports qualitative findings from semi-structured interviews.	$n = 45$ Bhutanese refugee women. Using convenience sampling, Bhutanese women were recruited through study flyers advertised in local Nepali grocery stores and through word of mouth via community contacts and study participants.	Semi-structured interview guide.	Bhutanese refugee women who resettled in the US reported an average of 3 close, personal supports during their pregnancy. Participants shared wellbeing and personal health experiences or concerns with these connections.
Kingsbury et al. (2019)	United States	Explore social support presence through the social networks of pregnant Bhutanese refugee women in Northeast Ohio. Examine which demographic characteristics of both participants and their close personal supports, are linked to strong social support.	This is a mixed methods study. This paper reports quantitative descriptive findings.	$n = 42$ Bhutanese refugee women. Same sampling as described above in Kingsbury et al., (2018) (data from 3 women excluded due to incomplete data).	Social support was defined and measured using a modified version of the Norbeck Social Support Questionnaire (NSSQ).	Bhutanese refugee women with perceived "high-support" social networks described their connections as "very close", primarily family members, and remained in contact with them every day.
LaMancuso et al. (2016)	United States	Gain insight into the perspectives of Karen refugee women, their medical practitioners, and Karen doulas regarding perinatal care among Karen women resettled in Buffalo, New York.	Qualitative: interviews. Analysed through template analysis.	$n = 28$ participants including Karen refugee women (14), Karen doulas/ interpreters and key informants (8) and medical practitioners (6). Karen women recruited through: Karen community; health centre; church service; clinic-employed interpreter. Karen doulas/interpreters were recruited using snowball sampling. A clinic physician informed medical practitioners of the study.	Semi-structured interviews, open-ended interview guide.	Women were considered "agreeable but shy". Perceived agreeableness, appreciation, and reluctance to voice concerns may be influenced by past trauma, limited self-efficacy, and cultural understandings. Karen doulas highlighted that doula training allowed them to support and advocate for their Karen clients.
McLaughlin & Guilfoyle (2013)	Australia	Understand the experiences of Burmese refugee women in a facilitated playgroup for their child/ren aged zero to five. Understand women's perceptions of this group in supporting their parenting.	Qualitative: semi-structured interviews and focus groups. An interpretative phenomenological approach was used.	$n = 9$ Burmese refugee women. Using criterion based homogenous sampling, women were recruited through a playgroup called, 'It Takes a Village' initiated by Save the Children Australia.	Interview schedules.	Women reported feeling isolated and lonely upon resettlement. The facilitated playgroup played a significant role in supporting women's wellbeing during the First 2000 Days by providing opportunities for women to develop connections with one another while providing

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Table 1 (*continued*)

Author, publication year	Country of study	Study aims	Study design and methodology	Sample/sampling	Measures	Findings relevant to review
						children the opportunity to learn and develop socialisation skills.
Niner et al. (2013)	Australia	Understand the impact of displacement for Karen refugee women and understand their pregnancy and birth experiences before and after resettlement in Australia.	Qualitative: interviews using narrative style ethnographic research.	$n = 15$ Karen refugee women recruited through purposive sampling via Karen community networks. This paper reported case studies for 8 of the 15 Karen women	Measure/s not stated.	Limited interpreting support and lack of personal support in general, made birth confusing, distressing, and hard to understand. For more complicated births, these negative experiences were amplified.
Riggs et al. (2016)	Australia	Overarching study aim: gain insight into the experiences of resettled Afghan women and men welcoming a baby in Melbourne, Australia. This paper explored the experiences of men and health practitioners, and their perspectives on the role of men in maternity and early childhood care.	Qualitative: interviews and focus groups. Analysed through thematic analysis. Involved a community-based participatory approach.	$n = 64$ participants including Afghan refugee men (14), Afghan refugee women (16), and healthcare providers (10 midwives, 5 medical practitioners, 19 community-based health workers, $n = 34$). Purposive and snowball sampling was used to recruit Afghan refugees with the aid of community researchers liaising with a Community Advisory Group, local services, and community groups. Purposive and snowball sampling was also used for healthcare practitioners.	Semi-structured interview guide.	Afghan men were heavily involved in supporting their wives during the antenatal period (e.g., transport and language support during appointments). While men played an active role, practitioners seldom asked fathers about their own social or psychological needs. Healthcare providers were unsure about their role in supporting men.
Riggs et al. (2017)	Australia	Explore the experiences of Karen refugee women involved in a community-based model of group pregnancy care. Understand what they liked and disliked, and whether the program supported them in preparing for childbirth and taking their newborn home.	Qualitative: focus groups. Analysed using thematic analysis.	$n = 19$ Karen refugee women. A bicultural worker invited women to participate if they had participated in the first year of the program and had given birth.	Semi-structured interview guide.	Sharing stories and experiences in a group-setting with peers encouraged Karen women to feel prepared and confident for pregnancy and birth. Women established trust with the multidisciplinary team, the bicultural worker playing an important role beyond translation and interpreting.
Riggs et al. (2020)	Australia	Overarching study aim: Gain insight into the experiences of resettled Afghan women and men delivering a baby in Melbourne, Australia. This paper explored the provision of health information for refugee Afghan women and men during the antenatal period and up to one year post-birth.	Same study design and methodology as described above in Riggs et al., (2016).	Same sample and sampling as described above in Riggs et al., (2016).	Semi-structured interview guide.	Afghan men and women had little to no interpreting support during labour and routine appointments, and experienced challenges in accessing interpreters fluent in their dialect. Families were unclear about the role of health providers in supporting them with issues beyond pregnancy and infant health.
Russo et al. (2015)	Australia	Examine the experiences of resettled Afghan women during the antenatal period and the initial stages of motherhood. Understand experiences which positively and negatively influence their emotional wellbeing.	Qualitative: interviews and focus groups. Analysed using thematic analysis and guided by feminist and sociocultural theoretical frameworks. Involved a community-based participatory approach.	$n = 38$ Afghan (Hazara) refugee participants. Using purposive sampling, participants were recruited by the bicultural research assistant and first author through informal visits to community playgroups.	Six-item theme list for open-ended questions.	Afghan women described postnatal emotional challenges similar to postnatal depression. Separation from family and culture were often described as factors which contributed to these emotional difficulties. Support provided by husbands was appreciated but challenging to navigate.
Yelland et al. (2014)	Australia	Overarching study aim: gain insight into the experiences of resettled	Same study design and methodology as described above in Riggs et al., (2016).	Same sample and sampling as described above in Riggs et al., (2016).	Semi-structured interview schedule.	Afghan women and men highlighted various social challenges during the

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Table 1 (*continued*)

Author, publication year	Country of study	Study aims	Study design and methodology	Sample/sampling	Measures	Findings relevant to review
		Afghan women and men delivering a baby in Melbourne, Australia. This paper explored men and women's experiences of the way by which healthcare providers enquired about various social and health concerns.				antenatal period, but health providers seldom enquired about their clients' social health and wellbeing.
Yelland et al. (2016)	Australia	Overarching study aim: gain insight into the experiences of resettled Afghan women and men delivering a baby in Melbourne, Australia. This paper explored men and women's experiences of language support during pregnancy appointments, labour, and birth.	Same study design and methodology as described above in Riggs et al., (2016).	Same sample and sampling as described above in Riggs et al., (2016).	Interview schedule.	Afghan families highlighted their limited access to interpreting support, with men primarily interpreting for their wives during imaging, pathology screening, labour, and birth. When interpreters were available to clients at no cost, they were often not consulted by providers.

Table 2
Overall study characteristics summary.

	Qualitative (n = 12)	Quantitative (n = 1)	Total n = 13
Year of Publication			
2000–2010	1		1
2011–2015	4		4
2016–2021	7	1	8
Country of study			
Australia	9		9
Canada	1		1
United States (US)	2	1	3
Informant group			
Refugees	7	1	8
Refugees and service providers	5		5
Cultural/ethnic background of refugee informant group			
Afghan (Hazara, Tajik, Pasthu)	5		5
Bhutanese	1	1	2
Burmese	1		1
Karen	3		3
Vietnamese, Karen, Karenni, Chin, Kachin	1		1
Vietnamese, Cambodian, Laotian	1		1
Sample size			
Under 20	4		4
21–40	3		3
41–60	1	1	2
60 +	4		4
Study timeframe[a]			
Antenatal[b] focus	10	1	11
Postnatal[c] focus	9		9
Early childhood[d] focus	1		1

[a] Some studies have a focus on both the antenatal and postnatal periods and have been categorised under both.

[b] We use the term 'antenatal' when referring to the period before birth (Department of Health, State Government of Victoria, Australia, 2021).

[c] Due to varying use of the term 'postnatal' and lack of definitions in the included studies, when referring to experiences in the 'postnatal' or 'post-birth' periods, definitions are kept broad to include the first 12 months post-birth (unless specified otherwise).

[d] We use the term 'early childhood' which refers to the period from birth up to child's age eight (UNESCO, 2022) (this includes the First 2000 Days, 0–5).

described, although the authors of this study did recognise the limitations of convenience sampling regarding generalisability (Kingsbury et al., 2019). In relation to the quality of the qualitative paper by Niner et al. (2013), three of the five MMAT criteria were met, however explanation regarding the methodology used was unclear, as was the interpretation of results as substantiated by the data, with limited discussion around the limitations of this study. In terms of risk of bias (Liberati et al., 2009), no studies disclosed conflicts of interest (see Appendix B for full quality appraisal table).

3.3. Wellbeing experiences

The following section outlines physical and emotional wellbeing experiences for S/SE Asian women predominantly in the antenatal and postnatal periods (research question 1). No papers explored the experiences of asylum seekers, or the physical wellbeing experiences of men during the First 2000 Days. Only one study explored the wellbeing experiences of Burmese refugee women in early childhood (McLaughlin & Guilfoyle, 2013), with no other studies focusing on experiences in the early childhood period (from approximately age two to five). Only four papers considered men, and none considered broader family members. As such, reference is made to 'women', with data extracted and discussed for men as available.

3.3.1. Wellbeing for S/SE Asian refugee parents

3.3.1.1. Emotional wellbeing. Nine papers reported on refugee women's emotional wellbeing experiences in the First 2000 Days (Hyman & Dussault, 2000; Joseph et al., 2019a; Kingsbury et al., 2018; LaMancuso et al., 2016; McLaughlin & Guilfoyle, 2013; Niner et al., 2013; Riggs et al., 2017; Russo et al., 2015; Yelland et al., 2014), although wellbeing was the primary focus of only one of these (Russo et al., 2015). In this qualitative study with 38 Afghan women, participants described grief and loss associated with the absence of women family members and friends post-birth in Australia. In the months post-birth, women described feelings of blame, guilt, despondency, anxiousness, tearfulness, and a decreased appetite – symptoms the authors suggest are related to postnatal depression (PND) (Russo et al., 2015). In the remaining eight papers, results related to emotional wellbeing were similar. For example, in the study by McLaughlin and Guilfoyle (2013) of nine Burmese refugee women participating in a facilitated playgroup in Australia, women reported feeling sad, extremely isolated, and were

worried about how this would impact their children (aged zero to five). Participants in one qualitative paper with 17 SE Asian refugee women in Canada noted financial pressures and the need to be employed as a key source of stress. One Laotian woman recounted her sister's arduous work experience: "She works very hard for a manufacturer. She is always standing. I encouraged her to apply for maternity leave but she worked until the end of her pregnancy. She was afraid to ask…" (Hyman & Dussault, 2000, p. 358).

While it is clear that S/SE Asian refugee women face challenges to wellbeing in the First 2000 Days, some women noted positive aspects and protective factors to support their wellbeing during this time. In the qualitative study with 38 Afghan women in Australia, positive influences included creating new friendships, enrolling in education or employment, connection to religion, and utilising day-care for children so women could have time for self-care and relaxation (Russo et al., 2015). Many S/SE Asian women also reported that maintaining cultural practices such as consuming traditional foods and celebrating birth with family positively influenced emotional and physical wellbeing in pregnancy and post-birth (Joseph et al., 2019a; Niner et al., 2013; Russo et al., 2015).

Four papers from the same overarching study highlighted 14 Afghan refugee men's perspectives of the antenatal and postnatal periods in Australia (Riggs et al., 2016; Riggs et al., 2020; Yelland et al., 2014, 2016). In one of these papers, men cited concerns around employment and financial security, which in turn led to some participants feeling anxious about being available to support their wives (Riggs et al., 2016). Some men experienced feelings of shame in relation to their presence at appointments and childbirth and involvement in infant care, as they indicated that this involvement was not typically considered the cultural norm (Riggs et al., 2016).

3.3.1.2. Physical wellbeing. In four papers, S/SE Asian refugee women discussed their physical health experiences during the antenatal (Hyman & Dussault, 2000; Kingsbury et al., 2018; Niner et al., 2013) and postnatal periods (Joseph et al., 2019a). The qualitative study by Niner et al. (2013) reported on both the emotional and physical antenatal and postnatal wellbeing experiences of eight Karen refugee women in Australia, finding that women focused more on physical wellbeing than mental health. While the three other studies that included physical wellbeing also considered wellbeing more broadly, the focus of the studies was placed on the physical health concerns of refugee women (Hyman & Dussault, 2000; Joseph et al., 2019a; Kingsbury et al., 2018).

In a qualitative US-based study, 45 Bhutanese refugee women described anxiety and worry around physical health aspects such as nutrition, symptoms such as ligament pain, swelling of hands and feet, body aches, GDM, and hypertension (Kingsbury et al., 2018). In a qualitative study of 17 Cambodian, Laotian, and Vietnamese refugee women, participants reported being concerned with weight and dieting during pregnancy, having implications for the prevalence of low birth weight among SE Asian women in Canada (Hyman & Dussault, 2000). In another qualitative study, 38 women from Vietnam and Myanmar in Australia encountered challenges encouraging breast milk production, where for some, being unable to observe traditional breastfeeding practices in the western biomedical setting led to early breastfeeding cessation and formula-feeding (Joseph et al., 2019a). In this study, one Karen mother described how vehicle motion was not safe for mother and baby post-birth, and travel for immunisations resulted in exposure to "lei zen" (described as raw breeze) and "shaking", affecting breastfeeding (Joseph et al., 2019a, p. 2862). Lastly, Karen refugee participants in the study by Niner et al. (2013) discussed physical challenges relating to childbirth and painful postnatal recovery.

3.3.2. Factors associated with wellbeing during the antenatal and postnatal periods

Ten papers explored factors associated with wellbeing for women (Joseph et al., 2019a; Kingsbury et al., 2018; LaMancuso et al., 2016; Niner et al., 2013; Riggs et al., 2016; Riggs et al., 2020; Riggs et al., 2017; Russo et al., 2015; Yelland et al., 2014, 2016) and three papers explored factors associated with wellbeing for men (Riggs et al., 2016; Riggs et al., 2020; Yelland et al., 2014) in the context of maternity healthcare. This section reports key themes identified from these papers, including trust in practitioners and the healthcare system, and satisfaction with the care received, as well as experiences of suboptimal maternity healthcare including a lack of culturally responsive care.

3.3.2.1. Trust and satisfaction. Eight papers included findings related to trust and satisfaction in healthcare services, finding that some refugee women (Joseph et al., 2019a; Kingsbury et al., 2018; LaMancuso et al., 2016; Niner et al., 2013; Riggs et al., 2017; Russo et al., 2015) and men (Riggs et al., 2016; Riggs et al., 2020) reported satisfaction and appreciation for the maternity care they received during resettlement. In these papers, participants often discussed these experiences favourably in comparison to the lack of formal care and often poor maternal and infant outcomes in their countries of origin. While the study by Russo et al. (2015) included participants who had given birth in the past five years, no studies reported on the experiences of S/SE Asian refugee families in the context of early childhood health, with experiences reported in these studies solely related to the antenatal and postnatal periods in maternity healthcare settings.

Four papers found that women refugees in Australia were appreciative of the sense of respect they felt they were accorded by healthcare providers during and after pregnancy. For example, Afghan women reported feeling respected and included in decision-making (Russo et al., 2015), Afghan and Karen women reported feeling comfortable to ask questions (Riggs et al., 2017; Riggs et al., 2020), Karen women felt looked after by nurses (Niner et al., 2013), and in one paper, Afghan men reported similar experiences: the nurses were, "very kind and nice…I think if there was anything in the world that could be done they would do it for us…" (Riggs et al., 2016, p. 90).

Despite the reported trust and satisfaction with maternity healthcare during resettlement, some women experienced a lack of safety within these settings. In one US-based qualitative study, while healthcare practitioners described their perception of Karen clients using words like "shy", "trusting" and "easy-going", (LaMancuso et al., 2016; p. 431), Karen doulas and interpreters who also participated emphasised that Karen patients were reluctant to voice concerns, partly due to past experiences of having questions met with admonishment in countries of origin (LaMancuso et al., 2016). As such, the authors suggested that Karen patients' reticence to voice concerns may be due to recurrent trauma, low-self-efficacy, and experiences of displacement, rather than feelings of trust (LaMancuso et al., 2016).

3.3.2.2. Lack of culturally responsive care. While some refugee families expressed trust and satisfaction with the level of maternity care in resettlement countries, seven qualitative papers found that refugee women from Myanmar and Afghanistan reported negative maternity healthcare experiences (Joseph et al., 2019a; LaMancuso et al., 2016; Niner et al., 2013; Riggs et al., 2016; Riggs et al., 2017; Russo et al., 2015; Yelland et al., 2014). These included not feeling comfortable to voice concerns and a lack of culturally responsive care.

Four further qualitative papers with Karen refugee women noted that participants reported experiences of discrimination, anxiety, distress, discomfort, and confusion in maternity healthcare contexts, with participants suggesting these experiences were connected to such factors as: being unable to give consent for certain medical procedures and not knowing what these procedures involved, being worried to speak given their limited English, being prohibited from undertaking culturally specific customs for labour and birth, and having limited privacy in the hospital (Joseph et al., 2019a; LaMancuso et al., 2016; Niner et al., 2013; Riggs et al., 2017). Niner et al. (2013) further noted that Karen refugee

women discussed barriers to self-advocacy, including feeling indebted to their country of resettlement (Australia) and a lack of interpreting support, with the latter also found by Riggs et al. (2017). The impact of limited interpreting support on refugee women's wellbeing is highlighted in the account of one Karen woman who was unable to inform practitioners of her postnatal anxiety and disturbing hallucinations in an Australian hospital, resulting in her being physically restrained: "Two nurses came and tied me up and I could not move…I felt like I was in a place where people are slaughtered" (Niner et al., 2013, p. 544).

Three other qualitative studies included Afghan women as participants and found similar themes of a lack of culturally responsive care, including shame and discomfort when women were denied female providers and interpreters in maternity care settings (Riggs et al., 2016; Russo et al., 2015; Yelland et al., 2014).

3.4. Support needs and experiences

The following section outlines the various interpersonal and formal support needs and experiences highlighted in the included papers (research question 2).

3.4.1. Interpersonal supports during the First 2000 Days

3.4.1.1. Support from women, family, and community. Nine papers emphasised the importance of social connections and family, especially women family members (e.g., maternal grandmothers, experienced mothers within the community) in supporting S/SE Asian women during pregnancy and early childhood (Joseph et al., 2019a; Kingsbury et al., 2018, 2019; McLaughlin & Guilfoyle, 2013; Niner et al., 2013; Riggs et al., 2016; Riggs et al., 2020; Russo et al., 2015; Yelland et al., 2014). Two of these studies (McLaughlin & Guilfoyle, 2013; Russo et al., 2015) emphasised how S/SE women mirrored relationships with women in their family by forming strong networks of women they met in their new country; Russo et al. (2015) reported that Afghan women in their study regarded these new women as "sisters or mothers" (p. 10). Similarly, nine Burmese women involved in a facilitated playgroup for children aged zero to five noted that by attending this formal support group, they established beneficial informal connections with other Burmese women in the group: "I get lots of help when I come to playgroup, as I have friends, and my children have friends, and I feel relaxed and enjoy meeting other parents" (McLaughin & Guilfoyle, 2013, p. 43). This was the only study included in this review which explored the wellbeing and support experiences of SE Asian refugee women during early childhood.

In three of these nine papers (Joseph et al., 2019a; Kingsbury et al., 2018, 2019) refugee women participants highlighted the importance of support provided by friends and family in their countries of origin who had also migrated and resettled in Australia and the US, thereby providing continued support to women during the antenatal and postnatal periods (Joseph et al., 2019a; Kingsbury et al., 2018, 2019).

3.4.1.2. Men's role in support. Four qualitative papers from the same study with 16 Afghan women and 14 Afghan men (Riggs et al., 2016; Riggs et al., 2020; Yelland et al., 2014, 2016) and one qualitative study with 38 Afghan women (Russo et al., 2015) found, for women migrating to Australia without extended family, husbands fulfilled varying roles. These roles included those that were typically occupied by women in home countries such as being present for their wife's labour and birth, attending antenatal and postnatal appointments with their wife, and providing emotional support during the pregnancy and postnatal period (Riggs et al., 2016; Riggs et al., 2020; Russo et al., 2015; Yelland et al., 2014, 2016). In relation to support for mental health and psychosocial concerns during the antenatal period, one Afghan woman participant noted, "…when the doctor say you need a professional, ah, no, we don't need…our friend or even our husband look after us…" (Russo et al., 2015, p. 6).

In four papers, Afghan men themselves described having an active role in supporting their wives during the antenatal and postnatal periods, including transporting their wives and attending and interpreting at appointments (Riggs et al., 2016; Riggs et al., 2020; Yelland et al., 2014, 2016). Only one of these papers (Riggs et al., 2020) reported briefly on Afghan men's own experiences of informal support, which related to men consulting friends who had settled in Australia longer than they had, for health information (Riggs et al., 2020). As such, the focus of these papers that included men related mainly to experiences of formal supports for Afghan families during the antenatal and postnatal periods.

3.4.2. Formal support

Ten studies focused on formal support, including the importance of community-based programs, interpreters, and the need for healthcare practitioners such as nurses and midwives in providing support to navigate the healthcare system of host countries (Joseph et al., 2019a; LaMancuso et al., 2016; McLaughlin & Guilfoyle, 2013; Niner et al., 2013; Riggs et al., 2016; Riggs et al., 2020; Riggs et al., 2017; Russo et al., 2015; Yelland et al., 2014,2016). Only one study (McLaughlin & Guilfoyle, 2013) focused on community-based group support in the early childhood period.

3.4.2.1. Community-based and group support. Two qualitative studies explored S/SE Asian refugee women's experiences of community-based group support (McLaughlin & Guilfoyle, 2013; Riggs et al., 2017). Riggs et al., (2017) evaluated a community-based model of group pregnancy care for 19 Karen women in Australia. Women reported feeling empowered and reassured about the process of giving birth as a result of the group setting. Participants said that this setting fostered friendship, providing a sense of social and emotional support for women (Riggs et al., 2017). The study also found that support from a bicultural worker was a key aspect of their care, providing support beyond interpreting.

3.4.2.2. Interpreting support. In six qualitative papers, S/SE Asian refugee women (and Afghan men in four of these papers) who were not fluent in English emphasised the importance of interpreters for communication and language support for maternity care appointments (Niner et al., 2013; Riggs et al., 2016; Riggs et al., 2020; Riggs et al., 2017; Yelland et al., 2014, 2016). For instance, Yelland et al. (2016) reported that two-thirds of Afghan women and men in their study expressed a need for interpreters during labour and birth, with over half not receiving this support at all.

Like S/SE Asian refugee families, providers who participated in the included studies also expressed concerns around the lack of adequate interpreting support. In three papers all from one study in Australia with 34 service providers, practitioners noted challenges in using husbands to interpret (e.g., practitioners being unable to talk about issues of family violence or mental health with women) (Riggs et al., 2020; Yelland et al., 2014, 2016). Practitioners also acknowledged that some Afghan parents may not be literate in their primary language so written support information, even when translated, may not be helpful (Riggs et al., 2020).

3.4.2.3. Support for men. In four qualitative papers with 14 Afghan refugee men in Australia, men described playing a key role in supporting their wives during the antenatal and postnatal periods (Riggs et al., 2016; Riggs et al., 2020; Yelland et al., 2014, 2016). This change in roles had implications for some men who, for example, experienced worry about balancing multiple expectations, including navigating resettlement, seeking employment, looking after their other children, and supporting their wives (Riggs et al., 2016). For instance, one man noted, "I don't have a job. If I had a job I couldn't help my wife", demonstrating the challenges in balancing availability to support their family and work (Riggs et al., 2016 p. 88). Some practitioners believed that managing

men's concerns during the antenatal and postnatal periods was not their role while others felt they were ill-equipped to provide support around specific needs as noted by a community-based provider, "There's things that we have no control over like English classes, finding jobs, driving instruction". (Riggs et al., 2016, p. 90).

Reflecting these issues, Afghan men reported that they were seldom asked by healthcare providers about their wellbeing including social health, financial concerns, legal and housing worries, relationship problems, or mental health during the antenatal period (Riggs et al., 2016; Riggs et al., 2020; Yelland et al., 2014). Men noted that they would have liked to have been asked about these concerns by providers, however, some were uncertain about the role of health professionals in discussing concerns other than pregnancy and infant wellbeing and noted that social health and familial issues were private matters not to be discussed with service providers (Riggs et al., 2020; Yelland et al., 2014). Men's support experiences were also impacted by the questions asked by health professionals: "the nurse was always just asking my wife if she had any problems with me. I didn't like that because that itself creates a problem between wife and a husband. I said they should also ask the male if they have any problems" (Yelland et al., 2014, p. 8). While some Afghan men reported trust with practitioners and satisfaction with maternity care in Australia (Riggs et al., 2016; Riggs et al., 2020), challenges remained around providing holistic wellbeing support for this group.

4. Discussion

Overall, this review found that S/SE Asian refugee women resettled in host countries (Australia, Canada, and the US) experience significant emotional (Hyman & Dussault, 2000; Joseph et al., 2019a; Kingsbury et al., 2018; LaMancuso et al., 2016; McLaughlin & Guilfoyle, 2013; Niner et al., 2013; Riggs et al., 2017; Yelland et al., 2014; Russo et al., 2015) and physical (Hyman & Dussault, 2000; Joseph et al., 2019a; Kingsbury et al., 2018; Niner et al., 2013) wellbeing challenges during the antenatal and postnatal periods. One study (four papers; Riggs et al., 2016; Riggs et al., 2020; Yelland et al., 2014, 2016) found that S/SE Asian (specifically Afghan) men experienced a multitude of stressors relating to supporting their family, including adopting multiple new roles, some of which were not consistent with cultural norms from their country of origin; yet their experiences and needs were seldom explored by practitioners. S/SE Asian women and Afghan men reported feelings of trust and satisfaction with maternity care, however issues with culturally responsive care were noted (Joseph et al., 2019a; LaMancuso et al., 2016; Niner et al., 2013; Riggs et al., 2016; Riggs et al., 2017; Russo et al., 2015; Yelland et al., 2014). Women also highlighted the importance of emotional, instrumental, and informational support from other women, family, and community, noting the impacts to wellbeing when these supports were absent during the antenatal and postnatal periods (Joseph et al., 2019a; Kingsbury et al., 2018, 2019; McLaughlin & Guilfoyle, 2013; Niner et al., 2013; Riggs et al., 2016; Riggs et al., 2020; Russo et al., 2015). While we have synthesised the literature for S/SE Asian refugee families related to pregnancy and immediate postnatal care, only one study explored women's support experiences through to early childhood (McLaughlin & Guilfoyle, 2013), and as such very little is known regarding wellbeing and support experiences for refugee families with children from approximately two to five years. Additionally, only one study included a focus on men, and no studies were found which explored the experiences of other family members, asylum-seekers, or the experiences of specific service providers in certain service contexts.

4.1. Findings in relation to wellbeing and support experiences in pregnancy and early parenthood

In relation to women's emotional wellbeing experiences in the antenatal and postnatal period, our review found that S/SE Asian refugee women experienced feelings of grief and loss (Russo et al., 2015), economic and employment pressures (Hyman & Dussault, 2000), and sadness and isolation (McLaughlin & Guilfoyle, 2013). These qualitative findings support an established body of quantitative research suggesting that pregnant refugee women experience significant impacts to emotional wellbeing during the antenatal and postnatal period (Collins et al., 2011; Rees et al., 2019). These impacts include a higher prevalence of major depressive disorder in pregnant refugee women (Rees et al., 2019) and increased risk of PND in migrant women (Collins et al., 2011). Similarly, the Building a New Life in Australia study – a large Australian longitudinal study with refugees – found that PTSD in refugee parents was associated with a "harsh" parenting style and in turn, was linked to child conduct problems, emotional concerns, hyperactivity, and peer problems (Bryant et al., 2018). Prolonged grief in this sample of parents was also directly linked to children's mental health outcomes (Bryant et al., 2020). These findings further speak to the need for additional research and culturally responsive supports for refugee families in the First 2000 Days to promote positive parent–child outcomes.

S/SE Asian refugee women also described significant impacts to wellbeing in the absence of familial supports during resettlement (Russo et al., 2015). Women emphasised the importance of emotional, instrumental, and informational support provided by people within their immediate interpersonal networks during the antenatal and early childhood periods. An established body of literature highlights the importance of familial support (particularly from women relatives) during these periods for both S Asian migrants (Kandasamy et al., 2020), and SE Asian migrants (Davis, 2001) in host countries.

Despite the wellbeing challenges experienced and reported by S/SE Asian women in the antenatal and postnatal period, women spoke to positive aspects that were beneficial to their wellbeing, including enrolling in education, and forming new social connections (Russo et al., 2015). These findings highlight the agency, initiative, and resilience of refugee women, as reported in previous literature (Hawkes et al., 2020).

In relation to physical health, some S/SE Asian participants placed greater focus on physical hardships over emotional concerns during their pregnancy and postnatally in resettlement (Niner et al., 2013). This may be explained by stigma around mental health in some cultures (Schmied et al., 2017), differences in mental health literacy (May et al., 2014; Yaser et al., 2016), beliefs that practitioners only address physical problems (Shafiei et al., 2015; Schmied et al., 2017), or cultural beliefs that the body is weak and prone to illness during the postnatal period (Davey & Vallianatos, 2018).

Notably, physical health concerns such as weight, dieting, the childbirth process, and pregnancy symptoms were also reported to impact emotional wellbeing with some participants feeling anxious or worried (Kingsbury et al., 2018). Previous research with migrant women has similarly found that women associated their physical health concerns (e.g., childbirth, weight, body odour, hormones) with feeling depressed (Ahmed et al., 2008).

As noted above, the review found only one study (four papers) that met inclusion criteria and included or reported on S/SE Asian refugee men in the First 2000 Days. Challenges around balancing multiple roles and finding employment were cited by Afghan refugee men (Riggs et al., 2016). These findings are consistent with previous research where refugee men reported mental stress due to financial pressures and unemployment, having impacts to men's self-esteem and identity in their role as primary provider and head of their family (Affleck et al., 2018; Hebbani, 2014). For some Afghan refugee men, involvement in antenatal appointments, birth, infant care, and providing emotional support to wives was challenging, and described by some as shameful (Riggs et al., 2016). These experiences may have similar implications for men's wellbeing including relationship challenges (Schmied et al., 2017), and feeling uncertain as to how to best support their wives during the antenatal or postnatal periods (Kululanga et al., 2012; Steen et al., 2012).

Previous research suggests that the engagement of fathers in antenatal care and appointments may promote fathers' mental health (Plantin et al., 2011; Wynter et al., 2021). When fathers are present, practitioners can take the opportunity to speak with men about their wellbeing and alleviate anxieties around birth and parenthood (Wynter et al., 2021). However, as found in the current review, there remains limited support and resources for refugee men during the antenatal and postnatal period.

In terms of experiences of support in the First 2000 Days, this review found that S/SE Asian refugee women often reported trust and satisfaction with the care and support received in the antenatal or postnatal periods (Joseph et al., 2019a; Kingsbury et al., 2018; LaMancuso et al., 2016; Niner et al., 2013; Riggs et al., 2017; Russo et al., 2015). These findings mirror previous research, where refugee and migrant women in Australia expressed trust in health workers, medicine, and technology (Billett et al., 2021). However, our review also found that some S/SE Asian refugee women were unable to engage in behaviours consistent with what would typically occur during the antenatal or postnatal periods according to their culture or own perspectives. As a result, women experienced difficulties within the healthcare system (LaMancuso et al., 2016; Niner et al., 2013). Previous research has also found that migrant Asian women in Australia reported confusion around conflicting antenatal and postnatal cultural practices, with women fearing the long-term physical health consequences of not following traditional customs (Hoang et al., 2009). These findings highlight the impacts of "cultural dissonance", or conflicts between traditional and western antenatal or postnatal practices (Russo et al., 2015, p. 5), which may lead some refugee women to feel distressed, upset, or uncomfortable when practitioners enforce certain restrictions on their behaviour during and after birth (Niner et al., 2013; Joseph et al., 2019a).

Similarly, in previous research with African refugee women, health professionals with little understanding of how culture informed pregnancy-related experiences were reported to influence women's perceptions around their fitness to parent, and for some refugee women, this led to disengagement from key services (Due et al., 2022). Leaving refugee women with existing wellbeing concerns unsupported can adversely impact physical and emotional wellbeing as seen in the current review, and this can further impact future help-seeking behaviour (O'Mahony et al., 2012).

4.2. Clinical implications and suggestions for future research

S/SE Asian refugee women reported a range of challenges experienced in maternity care settings in countries of resettlement, and findings from the current review indicate the need for culturally responsive care including provision of interpreters and continuity of care (CoC). A feature of the group-based model of care outlined by Riggs et al. (2017), involved CoC provided by a multidisciplinary team. Similarly, LaMancuso et al. (2016), indicated the importance of continued support from Karen doulas to establish trusting patient-practitioner relationships and enhance women's maternity experiences. CoC involves consistent support from the same providers antenatally, during pregnancy, and postnatally. This is a key aspect of culturally responsive care and is regularly cited by refugee women and health professionals in the broader literature to provide a sense of stability, security, improve patient-practitioner communication and trust, and reduce the need for women to repeatedly re-tell their history, including traumatic experiences (Rogers et al., 2020; Stapleton et al., 2013).

In considering the risk of re-traumatisation for refugee clients in maternity healthcare settings, culturally responsive care further points to the need for providers to incorporate trauma-informed care (TIC) (Due et al., 2022). TIC can empower refugee clients, increase their sense of control, and foster emotional, physical, and psychological safety (Pangas et al., 2019; Raja et al., 2015).

The studies included in this review also indicated a need for formal interpreters for appointments during the antenatal period (Niner et al., 2013; Riggs et al., 2016; Riggs et al., 2020; Riggs et al., 2017; Yelland et al., 2014, 2016). Another aspect of culturally responsive care, interpreters support refugee parents to better understand biomedical procedures, encourage appointment attendance, and reduce feelings of fear and confusion in maternity care settings (Carolan & Cassar, 2007; Correa-Velez & Ryan, 2012).

While our review search terms were broad and included terms such as 'early childhood' and 'preschool', very little research considered contexts beyond infancy. This is a key area for future research for S/SE Asian families, as previous literature has found that as children become older, refugee parents may require specific emotional, informational, and instrumental supports including: parenting support with a concurrent focus on parental mental health (Gillespie et al., 2022), information around child health promotion (Condon et al., 2020), and support in accessing childcare (Dolan & Sherlock, 2010). Moreover, no studies considered other family members, despite the fact that in many S/SE Asian cultures, care of children may also be the responsibility of broader family members (Kandasamy et al., 2020; Kurrien & Vo, 2004). Correspondingly, research on both early childhood and other family members is required when considering experiences, support, and wellbeing for S/SE Asian refugee families. Further research should also focus on the experiences of asylum-seeker families, as this group may experience greater health and psychosocial difficulties including increased risk for postnatal depressive symptoms for asylum-seeker women (Dennis et al., 2017).

Our review included studies which reported on the perspectives of service providers in maternity care settings. Future research should further explore the perspectives of specific providers working in this space (e.g., midwives, early childhood educators) to provide practitioner-specific and service-specific best-practice recommendations for health and social care policy in supporting S/SE Asian refugee families.

Lastly, the current review indicates a need for increased support to assist S/SE Asian refugee men with balancing multiple changing roles in a new cultural context, and greater care to support them through resettlement stressors impacting their wellbeing (Riggs et al., 2016).

Our review identified similarities in the wellbeing and support experiences of refugee women from S/SE Asia to those from other ethnocultural backgrounds. However, key differences remain, particularly in relation to obstetric outcomes. For example, higher rates of stillbirth for S Asian women (Berman et al., 2020; Davies-Tuck et al., 2017) and perineal trauma for S/SE Asian women (Brown et al., 2018; Sørbye et al., 2022) are well-reported in the broader literature, while women from Sub-Saharan Africa are at higher risk of pre-eclampsia and eclampsia (Urquia et al., 2014). Similarly postnatal practices vary across cultures, which further result in potential differences in wellbeing experiences and the care these groups receive in maternity settings (Joseph et al., 2019b). As such, a focus on refugees from specific regions are necessary to ensure tailored, culturally responsive care.

5. Limitations

Almost all studies included in the current review were published within the past 10 years, highlighting the relevancy of the topic and recency of findings, with study findings likely to be representative of refugees' current experiences. However, it is not without limitations. Our search strategy was limited to studies published in English, presenting a source of bias. Our review also highlights limitations of the broader literature on experiences in the First 2000 Days for refugee families. Only one study reported the experiences of refugee women beyond 12 months post-birth (McLaughlin & Guilfoyle, 2013); as such the review cannot provide evidence or recommendations about the wellbeing or support experiences of refugee women, men, and their families beyond this time, nor the experiences of asylum seeker families more generally. Only four included papers reported on Afghan refugee men's experiences, with no studies exploring men's experiences from

other S/SE Asian refugee groups during the First 2000 Days. Additional limitations of the broader literature include limited focus on the strengths, resilience, resources, and knowledge of refugee parents.

6. Conclusion

S/SE Asian refugee parents experience various physical and emotional wellbeing concerns in the antenatal and postnatal period. Challenges to obtaining culturally responsive antenatal and postnatal care in resettlement countries may further impact parent wellbeing. Lack of interpreting support and feeling unable to voice concerns negatively impacted women's wellbeing and healthcare experiences, while refugee men experienced challenges in balancing multiple changing roles and parenthood in a new country. Our review highlights the need for future research to explore the wellbeing and support experiences of S/SE Asian migrant families during the early childhood period, the experiences of asylum-seeker families and men, and focus on the resilience, resources, and strengths of these families to promote wellbeing in parenthood.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Data availability

See supplementary material

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Appendix A:. Database search strategies

CINAHL with Full Text (EBSCOhost).

MH immigrants + OR MH refugees OR MH "transients and migrants" OR TI migrant* OR AB migrant* OR TI "displaced person*" OR AB "displaced person*" OR TI CALD OR AB CALD OR TI "culturally and linguistically diverse" OR AB "culturally and linguistically diverse" OR TI.

immigrant* OR AB immigrant* OR TI "asylum seeker*" OR AB "asylum seeker*" OR TI "undocumented immigrant*" OR AB "undocumented immigrant*" OR TI "undocumented migrant*" OR AB "undocumented migrant*" OR TI resettlement OR AB resettlement OR TI newcomer* OR AB newcomer*.

AND.

MH "perinatal care" OR MH "prenatal care" OR MH "postnatal care" OR MH pregnancy + OR MH "postnatal period" OR MH infant + OR MH "child, preschool" OR TI prenatal OR AB prenatal OR TI perinatal OR AB perinatal OR TI antenatal OR AB antenatal OR TI postnatal OR AB postnatal OR TI pregnan* OR AB pregnan* OR TI postpartum OR AB postpartum OR TI infan* OR AB infan* OR TI child* OR AB child* OR TI "early life" OR AB "early life" OR TI "early child*" OR AB "early child*" OR TI preschool* OR AB preschool* OR TI toddler* OR AB toddler*.

AND.

MH "mental health" OR MH "psychological well-being" OR MH "depression, postpartum" OR MH emotion + OR MH "stress disorders, post-traumatic+" OR TI wellbeing OR AB wellbeing OR TI "well being" OR AB "well being" OR TI "mental health" OR AB "mental health" OR TI psychosocial OR AB psychosocial OR TI socioemotional OR AB socioemotional OR TI depress* OR AB depress* OR TI anxi* OR AB anxi* OR TI PTSD OR AB PTSD OR TI "posttraumatic stress disorder" OR AB "posttraumatic stress disorder" OR TI "postnatal depression" OR AB "postnatal depression" OR TI "postpartum depression" OR AB "postpartum depression".

AND.

MH caregivers OR MH parents + OR MH "family relations+" OR MH "extended family+" OR TI parent* OR AB parent* OR TI mother* OR AB mother* OR TI father* OR AB father* OR TI grandp* OR AB grandp* OR TI matern* OR AB matern* OR TI patern* OR AB patern* OR TI carer* OR AB carer* OR TI caregiver* OR AB caregiver* OR TI grandfather* OR AB grandfather* OR TI grandm* OR AB grandm* OR TI aunt* OR AB aunt* OR TI uncle* OR AB uncle*.

Embase and Emcare (Ovid).

exp migrant OR refugee*.tw OR migrant*.tw OR displaced person*.tw OR CALD.tw OR (culturally and linguistically diverse).tw OR immigrant*.tw OR asylum seeker*.tw OR undocumented immigrant*.tw OR undocumented migrant*.tw OR resettlement.tw OR newcomer*.tw.

AND.

exp perinatal care OR exp perinatal period OR exp pregnancy OR exp infant OR exp toddler OR exp preschool child OR exp postnatal care OR exp pregnant woman OR prenatal.tw OR perinatal.tw OR antenatal.tw OR postnatal.tw OR pregnan*.tw OR postpartum.tw OR.

infan*.tw OR child*.tw OR early life.tw OR early child*.tw OR preschool*.tw OR pre-school*.tw OR toddler*.tw.

AND.

exp mental health OR exp wellbeing OR exp perinatal depression OR exp anxiety disorder OR exp emotion OR wellbeing.tw OR well being.tw OR mental health.tw OR psychosocial.tw OR socioemotional.tw OR depress*.tw OR anxi*.tw OR PTSD.tw OR posttraumatic stress disorder.tw OR postnatal depression.tw OR postpartum depression.tw.

AND.

exp caregiver OR exp parent OR exp child parent relation OR exp grandparent OR exp extended family OR exp aunt OR exp uncle OR parent*.tw OR mother*.tw OR father*.tw OR grandp*.tw OR matern*.tw OR patern*.tw OR carer*.tw OR caregiver*.tw OR grandfather*.tw OR grandm*.tw OR aunt*.tw OR uncle*.tw.

PsycINFO (APA Ovid).

exp refugees OR exp immigration OR exp asylum seeking OR refugee*.tw OR migrant*.tw OR displaced person*.tw OR CALD.tw OR (culturally and linguistically diverse).tw ORimmigrant*.tw OR asylum seeker*.tw OR undocumented immigrant*.tw OR undocumented migrant*.tw OR resettlement.tw OR newcomer*.tw.

resettlement.tw

AND.

exp perinatal period OR exp postnatal period OR exp prenatal care OR exp pregnancy OR exp early childhood development OR prenatal.tw OR perinatal.tw OR antenatal.tw ORpostnatal.tw OR pregnan*.tw OR postpartum.tw OR infan*.tw OR child*.tw OR early life.tw OR early child*.tw OR preschool*.tw OR pre-school*.tw OR toddler*.tw.

postnatal.twpostpartum.twlife.tw.

AND.

exp well being OR exp mental health OR exp postpartum depression OR exp anxiety OR exp "depression (emotion)" OR exp posttraumatic stress disorder OR exp stress OR wellbeing.tw OR well being.tw OR mental health.tw OR psychosocial.tw OR socioemotional.tw OR depress*.tw OR anxi*.tw OR PTSD.tw OR posttraumatic stress disorder.tw ORpostnatal depression.tw OR postpartum depression.tw.

depression.twdepression.tw

AND.

exp parenting OR exp caregivers OR exp family members OR exp family relations OR parent*.tw OR mother*.tw OR father*.tw OR grandp*.tw OR matern*.tw OR patern*.tw OR aunt*.tw OR uncle*.tw OR grandfather*.tw OR grandm*.tw OR carer*.tw OR caregiver*.tw OR extended famil*.tw.

PubMed.

"refugees"[mh] OR "emigrants and immigrants"[mh] OR refugee*[tw] OR migrant*[tw] OR displaced person*[tw] OR CALD[tw] OR "culturally and linguistically diverse"[tw] OR immigrant*[tw] OR asylum seeker*[tw] OR undocumented migrant*[tw] OR undocumented immigrant*[tw] OR resettlement[tw] OR newcomer*[tw].

AND.

"perinatal care"[mh] OR "prenatal education"[mh] OR "child, preschool"[mh] OR "infant"[mh] OR "postpartum period"[mh] OR "pregnancy"[mh] OR "pregnant women"[mh] OR perinatal[tw] OR prenatal[tw] OR antenatal[tw] OR postnatal[tw] OR pregnan*[tw] OR postpartum[tw] OR infan*[tw] OR child*[tw] OR early life[tw] OR early child*[tw] OR preschool*[tw] OR toddler*[tw].

AND.

"depression, postpartum"[mh] OR "mental health"[mh] OR "depression"[mh] OR "anxiety"[mh:noexp] OR "Stress Disorders, traumatic"[mh] OR wellbeing[tw] ORwell being[tw] OR psychosocial[tw] OR emotional[tw] OR depress*[tw] OR anxi*[tw] OR PTSD[tw] OR posttraumatic stress disorder[tw] OR postnatal depression[tw].

AND.

"parents"[mh] OR "family relations"[mh] OR "grandparents"[mh] OR "caregivers"[mh] OR parent*[tw] OR mother*[tw] OR father*[tw] OR matern*[tw] OR patern*[tw] OR grandm*[tw] OR grandfather*[tw] OR family relation*[tw] OR caregiver*[tw] OR carer*[tw] OR aunt*[tw] OR uncle*[tw] OR extended famil*[tw] OR grandp*[tw].

Scopus (Elsevier).

refugee* OR migrant* OR "displaced person*" OR CALD OR "culturally and linguistically diverse" OR immigrant* OR "asylum seeker*" OR "undocumented immigrant*" OR "undocumented migrant*" OR resettlement OR newcomer*.

AND.

perinatal OR prenatal OR antenatal OR postnatal OR pregnan* OR postpartum OR infan* OR.

child* OR "early life" OR "early child*" OR "pre-school child*" OR birth OR preschool* OR pre-school* OR toddler*.

AND.

wellbeing OR "well being" OR "mental health" OR psychosocial OR socioemotional OR.

"social health" OR depress* OR anxi* OR PTSD OR "posttraumatic stress disorder*" OR.

"postnatal depression" OR "postpartum depression" OR stress OR emotion*.

AND.

parenting OR parent* OR mother* OR father* OR grandp* OR matern* OR patern* OR "family relation*" OR aunt* OR uncle* OR grandm* OR grandfather* OR "extended famil*" OR carer* OR caregiver*.

Appendix B. Mixed Methods Appraisal Tool (MMAT) quality assessment results

MMAT category of study design	Author, publication year	Responses					MMAT methodological quality criteria (Hong et al., 2018)
Qualitative		1.1	1.2	1.3	1.4	1.5	
	Hyman and Dussault (2000)	●	●	●	●	●	**1.1 Is the qualitative approach appropriate to answer the research question?** **1.2. Are the qualitative data collection methods adequate to address the research question?** **1.3. Are the findings adequately derived from the data?** **1.4 Is the interpretation of results sufficiently substantiated by data?** **1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?**
	Joseph et al. (2019a)	●	●	●	●	●	
	Kingsbury et al. (2018)	●	●	●	●	●	

(*continued on next page*)

(*continued*)

MMAT category of study design	Author, publication year	Responses					MMAT methodological quality criteria (Hong et al., 2018)
Qualitative		**1.1**	**1.2**	**1.3**	**1.4**	**1.5**	
	LaMancuso et al. (2016)	🟢	🟢	🟢	🟢	🟢	
	McLaughlin and Guilfoyle (2013)	🟢	🟢	🟢	🟢	🟢	
	Niner et al. (2013)	🟢	🟢	🟢	🔴	🟡	
	Riggs et al. (2016)	🟢	🟢	🟢	🟢	🟢	
	Riggs et al. (2017)	🟢	🟢	🟢	🟢	🟢	
	Riggs et al. (2020)	🟢	🟢	🟢	🟢	🟢	
	Russo et al. (2015)	🟢	🟢	🟢	🟢	🟢	
	Yelland et al. (2014)	🟢	🟢	🟢	🟢	🟢	
	Yelland et al. (2016)	🟢	🟢	🟢	🟢	🟢	
Quantitative descriptive		**4.1**	**4.2**	**4.3**	**4.4**	**4.5**	
	Kingsbury et al. (2019)	🔴	🔴	🟡	🟢	🟢	**4.1 Is the sampling strategy relevant to address the research question?** **4.2 Is the sample representative of the target population?** **4.3 Are the measurements appropriate?** **4.4 Is the risk of nonresponse bias low?** **4.5 Is the statistical analysis appropriate to answer the research question?**

Appendix C. Supplementary material

Supplementary data to this article can be found online at https://doi.org/10.1016/j.childyouth.2023.107222.

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